Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ADJETEY LOMO MD
3100 TIMMONS LN STE 250
HOUSTON TX 77027

Respondent Name

ACIG INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-0011-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER FAILED TO PAY THIS CLAIM PROPERLY EVEN AFTER SENT BACK AS REQUEST FOR RECONSIDERATION AND NEVER RESPONDED TO REQUEST FOR RECONSIDERATION"

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A Re-evaluation produced no further recommendation for payment."

Response Submitted by: NOVAPRO RISK SOLUTIONS, LP, 10210 N. CENTRAL EXPWY, #500, DALLAS TX 75231

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2010	99456-WP-W5, 99456-RE-W8, 99080-73	$165.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 17, 2010
   - W1 – Workers' Compensation State Fee Schedule Adj
   - ORC – See additional information
   - B15 – Procedure/Service is not paid separately.
   - ORC – See additional information
   - Bill Comments: DDE Exam, MMI 5-12-10, ROM 3 BODY PARTS

   Explanation of benefits dated June 30, 2010
   - R01 – Duplicate billing
   - B13 – Payment for service may have been previously paid

   Explanation of benefits dated July 29, 2010
   - R01 – Duplicate billing
   - Original bill [1548593,9]
   - B13 - Payment for service may have been previously paid.

Issues

1. Did the requestor bill and document appropriately Medical Improvement/Impairment and Return to Work examinations, as well as a DWC 73 Work Status report according to 28 Texas Administrative Code §134.204?
2. Has respondent made a duplicate payment?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds that MMI was assigned as well as an IR using various methods on different body areas and conditions and billed using CPT code 99456-W5-WP. Per 28 Texas Administrative Code §134.204(j)(3)(C), the requestor is due $350.00 for the MMI calculation. Per 28 Texas Administrative Code§134.204(j)(C)(ii)(II)(a)(b), the requestor is due $300.00 for the musculoskeletal range of motion (ROM) on 1st area (upper extremities) and $150.00 for ROM to 2nd area (lower extremities). Per 28 Texas Administrative Code §134.204(j)(C)(ii)(I), the requestor is due $150.00 for DRE method used on spinal region. The Respondent already has paid the MAR of $950.00 for three musculoskeletal body areas represented by the diagnoses codes on the billing. Requestor also has a rating for 5% mental impairment. There is no mental status or depression diagnosis code on the CMS-1500. The examining doctor states "the examinee needs to see a psychiatrist….appears to be depressed." Documentation does not support that any psychological testing was performed to render such a determination. Therefore, no additional is due on the MMI/IR service. The CPT code 99456-RE-W8 Return to Work exam was due $500.00 and has been already been reimbursed. Per 28 Texas Administrative Code §134.204(k) as the RTW exam "shall include Division-required reports". Therefore, the CPT code 99080-73 Work Status Report is global and the charge for $15.00 is not recommended for payment.
2. The respondent denied reimbursement based upon duplicate charges using denial code R01 – Duplicate billing. The disputed service was a duplicate bill submitted for reconsideration of payment. The respondent did not provide information/documentation of duplicate payments. Therefore, this denial reason has not been supported.
3. The requestor has not shown that any further reimbursement is due.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		October 04, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.